OMB Approved No. 2900-0161
Respondent Burden: 12 minutes

Department of Veterans Affairs

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN *(First,middle,last)*		2. VA FILE NUMBER
3A. NAME AND ADDRESS OF CLAIMANT	3B. CHANGE OF ADDRESS *(Check box if address in Item 3A is different from last address furnished to VA)* ☐	4. VETERAN'S SOCIAL SECURITY NO.

NOTE: Family medical expenses are amounts actually paid by you during the income reporting year for medical expenses for which you are not reimbursed by insurance or any other source. Report the actual unreimbursed amount you paid for medical expenses for yourself and any relatives you are under an obligation to support. Do not report any expenses you have not paid or expenses paid for you by someone else. If there is not enough space to report all your expenses on this form, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

You may report any medical expenses which are reasonably related to medical care. Example of allowable medical expenses include the following: hospital expenses, office visits, drugs and medicines, eyeglasses, dental fees, medical insurance premiums (including the Medicare deduction), hearing aids, nursing home fees, home health services, and transportation for medical purposes (.20 per mile plus parking and tolls or fares for taxis, buses, etc.). If you are not sure whether a particular expense is allowable, list it and fully describe the nature of the expense. VA will determine whether it can form the basis for a deduction.

Report medical expenses for the period thru . If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates your medical expense report should cover.

5. ITEMIZATION OF MEDICAL EXPENSES

A. PURPOSE *(Physician or Hospital Charges Eyeglasses, Oxygen Rental Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID (Mo/Day/Yr)	D. NAME OF PROVIDER *(Name of Doctor, Dentist, Hospital, Lab, etc.)*	E. FOR WHOM PAID (Self, spouse, child)
MEDICARE (PART B)			SOCIAL SECURITY	
PRIVATE MEDICAL INSURANCE				

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

5. ITEMIZATION OF MEDICAL EXPENSES (*Continued)*

A. PURPOSE *(Physician or Hospital Charges Eyeglasses, Oxygen Rental Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID (Mo/Day/Yr)	D. NAME OF PROVIDER *(Name of Doctor, Dentist, Hospital, Lab, etc.)*	E. FOR WHOM PAID (Self, spouse, child)

I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

6A. DAYTIME TELEPHONE NO. *(Include Area Code)*	6B. EVENING TELEPHONE NO. *(Including Area Code)*

7A. SIGNATURE OF CLAIMANT *(Do NOT print)*	7B. DATE

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT INFORMATION: No exclusion from income may be granted unless this form is completed and returned as required by existing law (38 CFR 3.272). The responses you submit are considered confidential (38 U.S.C. 5701) and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits provided under law. Information submitted is subject to verification through computer matching programs with other agencies. Income information and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986. Any information provided by you, including your Social Security Number, may be used in matching programs conducted in connection with any proceeding for the collection of an amount owed the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.